ERRATA

TO: All County Welfare Directors

SUBJECT: Correction to form Temp 1496 (10/81) Domestic Service Transmitted by ACL No. 81-127

The second paragraph of form Temp 1496 (10/81) referencing the authorization level prior to reduction was printed incorrectly. Attached is a corrected copy that can be used for reproduction or as a guideline for correcting copies that have been reproduced.

1/6/82

IN—HOME SUPPORTIVE SERVICES (IHSS)

NOTICE OF ACTION

NOTE: *The action described below relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.*

Case Number: _____

Date Mailed: _____

SPECIAL NOTICE

This is a special notice which is being sent to you concerning your In-Home Supportive Services. On _____ you were sent a notice from the county welfare department which either reduced or terminated your In-Home Supportive Services due to a change in State law. **That notice may not have properly and completely informed you of your right to request a state hearing and of your right to receive aid paid pending the state hearing.** PLEASE CAREFULLY READ ALL OF THE FOLLOWING NOTICE WHICH WILL GIVE YOU INFORMATION ON THE NATURE OF THE COUNTY WELFARE DEPARTMENT'S ACTION AND ITS EFFECT ON YOUR IN-HOME SUPPORTIVE SERVICES. If you have any questions after reading this information or believe other facts should be considered, please immediately call your Agency Representative.

Your In-Home Supportive Services (IHSS) were reduced to _____ hours and ($_____) per month effective _____. Prior to this reduction, you received _____ hours and ($_____) per month. The changes are as follows:

	Hours per month before reduction	**Hours per month now allowed**
Domestic services: (Such as sweeping, garbage removal, putting away food and changing bed linen.)	_____	_____

The county welfare department has determined that the level of domestic services you have been granted will not result in your loss of employment, placement in a medical out-of-home care facility, a condition which threatens your life or a substantial threat to your health or safety. The determination regarding the number of hours allocated to you for domestic services was based on:

_____ You are the only person counted in your household.

_____ You are receiving a pro rata share of the entire domestic services allowance based on _____ people living in your household.

The action taken above was required by regulations **MPP 30-450 and 30-458.**

IF YOU DISAGREE WITH THE DETERMINATION WHICH RESULTED IN THE REDUCTION OR TERMINATION OF YOUR IHSS, SEE REVERSE SIDE OF THIS FORM FOR YOUR RIGHT TO REQUEST A STATE HEARING AND TO RECEIVE AID PAID PENDING THE HEARING.

_____ Agency Representative

_____ Telephone Number

Your Right to Appeal This Action

If you are dissatisfied with the County's original action, you may request a state hearing before a Hearing Officer of the State Department of Social Services even though your original notice may have led you to believe otherwise. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a state hearing, you may do so within **90 DAYS OF THE MAILING OF THIS NOTICE.**

IF YOU ASK FOR A HEARING WITHIN 10 DAYS OF THE MAILING DATE OF THIS NOTICE, YOU WILL RECEIVE AID PAID PENDING THE STATE HEARING, AT THE LEVEL OF SERVICES YOU RECEIVED BEFORE THE COUNTY'S ORIGINAL ACTION.

Aid paid pending will be effective as of the date of the County's original action.

You will not be liable for repayment of services or monies received pending the hearing, even if the result is a denial.

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

TDD (800) 952-8349* For the Deaf Only

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to In-Home Supportive Services

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.